U.S. Department of Labor

Office of Administrative Law Judges
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Date: **November 9, 2000**

Case No.: **1993-LHC-6767**

OWCP No.: **06-091781**

In the Matter of:

B.J. SISTRUNK (DECEASED)
FLORA SISTRUNK (WIDOW)

Claimant

v.

INGALLS SHIPBUILDING, INC.

Employer

APPEARANCES:

Robin Reid Boswell, Esq.

For the Claimant

Donald P. Moore, Esq.

For Employer

Before: LEE J. ROMERO, JR.
Administrative Law Judge

DECISION AND ORDER

This is a claim for benefits under the Longshore and Harbor Workers' Compensation Act (herein the Act), 33 U.S.C. § 901, et seq., brought by Flora Sistrunk (Claimant and Widow of B.J. Sistrunk) against Ingalls Shipbuilding, Inc. (Employer).

The issues raised by the parties could not be resolved administratively and the matter was referred to the Office of

Administrative Law Judges on December 31, 1997, for hearing. Pursuant thereto, Notice of Hearing issued scheduling a formal hearing on August 22, 2000, in Gulfport, Mississippi. All parties were afforded a full opportunity to adduce testimony, offer documentary evidence and submit post-hearing briefs. Claimant offered forty-nine exhibits while Employer proffered thirteen exhibits which were admitted into evidence along with one Joint Exhibit. This decision is based upon a full consideration of the entire record.[1]

Post-hearing briefs were received from Claimant and Employer. Based upon the stipulations of Counsel, the evidence introduced, my observations of the demeanor of the witnesses, and having considered the arguments presented, I make the following Findings of Fact, Conclusions of Law and Order.

I. STIPULATIONS

At the commencement of the hearing, the parties stipulated (JX-1), and I find:

1. That jurisdiction of this claim is under the Act.

2. That decedent was an employee of Ingalls Shipbuilding, Inc.

3. That Employer was timely advised of the injury/death.

4. That Employer filed a timely Notice of Controversion.

5. That decedent’s date of death was January 13, 1995.

6. That the national average weekly wage at the time of decedent’s death was $380.46.

7. That Claimant was married to and a dependent of decedent at the time of his death.

8. That Employer was decedent’s last maritime employer.

9. That asbestos products were present at Employer’s

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[1] References to the transcript and exhibits are as follows: Transcript: Tr.___ ; Claimant's Exhibits: CX-___; Employer Exhibits: EX-___; and Joint Exhibit: JX-___.

shipyard when decedent worked there.

II. ISSUES

The unresolved issues presented by the parties are:

1. Causation;

2. Whether Section 33 of the Act bars Claimant's rights to recover benefits due to unapproved third-party settlements;

3. Whether Section 33 of the Act entitles Employer to a credit for pre-death settlements; and

4. Interest and attorney's fees.

III. STATEMENT OF THE CASE

The Testimonial Evidence

Flora Sistrunk

Ms. Flora Sistrunk testified she was married to B.J. Sistrunk at the time of his death on January 13, 1995. (Tr. 26). She reported she first married B.J. Sistrunk in 1946. (Tr. 38). She noted they divorced and were remarried. (Tr. 43). Their second marriage occurred on April 21, 1986. (CX-49).

Ms. Sistrunk stated she paid $4,695.00 for Mr. Sistrunk's funeral. (Tr. 28). She acknowledged she authorized the law firm of Maples and Lomax to act on her behalf vis-a-vis her longshore claim. (Tr. 29-30). She confirmed she has not received any money from any third-party or asbestos defendant nor has she signed any releases since her husband died. (Tr. 30, 45). Moreover, she has not "personally cashed any asbestos third-party checks since [her] husband died." (Tr. 31).

Ms. Sistrunk reported when B.J. Sistrunk would receive money from his third-party settlements, he would "give [her] what, I guess, he wanted to." (Tr. 57-58).

The Medical Evidence

W. Hayden Childs, M.D.

Dr. Hayden Childs, in a letter to Attorney Lowry Lomax, reviewed an x-ray, dated May 25, 1985, of B.J. Sistrunk's chest and noted small pleural plaques along the lateral thoracic walls. He summarized "there are some radiographic changes suggestive of asbestos related lung disease if exposure history is appropriate." (CX-2).

Gaeton D. Lorino, M.D.

Dr. Gaeton Lorino, in a letter to Attorney Lowry Lomax, examined B.J. Sistrunk on December 12, 1985, and received a history from him which revealed Mr. Sistrunk worked at Employer's shipyard from 1945 to 1948 as a welder and from 1951 until the examination. Mr. Sistrunk informed Dr. Lorino that his asbestos exposure had been heavy throughout most of those years. Dr. Lorino noted Mr. Sistrunk smoked one pack of cigarettes daily and had done so for about twenty or twenty-five years. (CX-3, p. 2).

Dr. Lorino noted Mr. Sistrunk had been having increased shortness of breath over the last two or three years. Mr. Sistrunk presented with a cough usually productive of yellowish to greenish sputum. A pulmonary function study "showed mild obstructive air ways disease which did not show any reversible component. There is also a moderate ventilatory defect present. Lung volumes within normal limits as well as the diffusion capacity." (CX-3, p. 2).

Dr. Lorino evaluated Mr. Sistrunk's chest x-ray which revealed "bilateral pleural plaque formation as well as increased reticulonodular infiltrate." No independent x-ray report from a radiologist accompanied Dr. Lorino's report. Dr. Lorino assessed:

1. Asbestos related lung disease as manifested by:
   (a) history of exposure
   (b) shortness of breath
   (c) bilateral pleural thickening with chest x-ray
2. Early chronic bronchitis
3. Rhinophyma. (CX-3, p. 3).

Singing River Hospital

An October 7, 1994 x-ray report, requested by Dr. Calvin Ennis and completed by Dr. Jeff Hodges, indicated B.J. Sistrunk had an abnormal chest examination marked by a large cavitary lesion. Dr. Hodges noted "air fluid level with pneumonic infiltrate consistent with abscess probably posterior segment right upper lobe." No "bilateral pleural plaque formations" were noted. (CX-9).

An October 11, 1994 x-ray report, referred by Dr. Ennis and Dr. David Witty and completed by Dr. Paul Moore, provided an impression that "mass within the posterior segment of the right upper lobe measuring approximately 6.3 x 8.2 cm in diameter. With a fluid level within. This is thought to be a pulmonary abscess without hilar adenopathy." There was no notation of the presence of "bilateral pleural plaque formations." (CX-10).

An October 13, 1994 x-ray report, referred by Drs. Ennis and Witty and completed by Dr. Hodges, indicated Mr. Sistrunk had a "large cavitary lesion right upper lung field posterior segment, probably abscess, essentially unchanged compared to 10/7/94 with same impression and conclusions to be drawn." Again, no bilateral pleural plaque formations were noted. (CX-11).

An October 18, 1994 x-ray report, referred by Dr. Ennis and completed by Dr. Hal Moore, noted Mr. Sistrunk had an "abnormal chest unchanged since 10/13/94." No pleural plaque formations were noted. (CX-12).

An October 20, 1994 x-ray report, referred by Drs. Ennis and Witty and completed by Dr. William Ehlert, reported Mr. Sistrunk's "right upper lobe cavitary mass with moderate adjacent infiltrates, essentially unchanged since 10/11/94." No pleural fluid was seen nor pleural plaque formations noted. (CX-13).

An October 23, 1994 x-ray report, referred by Drs. Ennis and Witty and completed by Dr. Ehlert, stated "a large dense infiltrate persists in the right upper lung field with a 4 cm cavity, essentially unchanged since 10/18/94 except the air fluid level is not visualized in this position. No other complications seen." No pleural plaquing was noted. (CX-14).

An October 24, 1994 pathology report, completed by Dr. James Stith, detailed right upper lobe lung biopsies were taken. The microscopic diagnosis indicated "bronchial wall showing submucosal, poorly differentiated infiltrating carcinoma

consistent with undifferentiated large cell carcinoma; fibrotic and focally necrotic[2] apparent lung tissue showing multiple ferruginous[3] bodies." Dr. Stith commented "the carcinoma present in one of the biopsy fragments is of nonsmall cell type. A few, minute fragments of neoplasm[4] are observed in two of the other biopsy fragments and show similar cytologic characteristics. A mucicarmine stain is negative for epithelial mucin. Most of the ferruginous bodies observed in these biopsy fragments are not of asbestos type, but occasional bodies show the morphologic characteristics of asbestos bodies." (CX-17).

Pulmonary function reports were made at Singing River Hospital on October 27 and 28, 1994. The reports noted Mr. Sistrunk stated he had asbestosis. The reports observed Mr. Sistrunk had a fifty-year history of smoking one-half packs of cigarettes daily. (CX-15; CX-16).

A January 8, 1995 x-ray report, requested by Dr. Ennis and Dr. Richard Bucci and completed by Dr. Hal Moore, indicated "an 11 cm consolidation is present at the level of the right upper lung. A cavitary infiltrate was previously present at this site. The lungs are otherwise clear. The cardiac silhouette is unremarkable. Osteoarthritic changes of the thoracic spine are noted." Dr. Moore proffered an impression "markedly abnormal chest with a large consolidation present at the level of the right upper lung." However, no pleural plaque formations were reported. (CX-22).

A January 9, 1995 total body bone scan, referred by Dr.

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[2] Necrotic refers to the sum of the morphological changes indicative of cell death and caused by the progressive degradative action of enzymes; it may affect groups of cells or part of a structure or an organ. Dorland's Illustrated Medical Dictionary 1103 (28th ed. 1994).

[3] Ferruginous signifies containing iron or iron rust. Id. at 617.

[4] Neoplasm is any new and abnormal growth; specifically, a new growth of tissue in which the growth is uncontrolled and progressive. Malignant neoplasms are distinguished from benign in that the former show a greater degree of anaplasia and have the properties of invasion and metastasis. Also called a tumor. Id. at 1107.

Ennis and completed by Dr. Hodges, observed "abnormal total body bone scan. Changes upper lumbar spine corresponding to compression fracture with increased activity posterior mid rib on the left and probably right femur distally. The vertebral activity is not identifiably etiologically, consistent with traumatic compression fracture. The posterior mid rib on the left is suspicious for neoplastic changes as is the distal right femur. Follow-up examination or further evaluation suggested. Clinical correlation and further evaluation regarding the marked changes right chest. This represents a notably worsened appearance compared to a cavitary lesion noted right mid lung field on 10/25/94." No pleural plaque formations were noted. (CX-23).

Calvin Ennis, M.D.

Dr. Calvin Ennis examined B.J. Sistrunk on October 12, 1994, and received a history which revealed Mr. Sistrunk was a seventy year old man complaining of fever and malaise. Dr. Ennis reported "[Mr. Sistrunk's] blood sugar was almost 400 and he had some rales in his right mid lung. I thought he had a pneumonia associated with uncontrolled diabetes and is now hospitalized. He does not take good care of himself; he drinks everyday, probably in the rage (sic) of at least 6 cans of beer per day and has stopped taking his oral hyperglycemic agents and I have not seen him in the office, probably for two years." (CX-5, p. 1). Dr. Ennis diagnosed Mr. Sistrunk's condition as "uncontrolled diabetes, right middle lobe pneumonia and rhinophyma." (CX-5, p. 2).

Dr. Ennis examined Mr. Sistrunk on November 3, 1994, and observed Mr. Sistrunk "had a cavitation in his right upper lung. Dr. Witty consulted and after acid fast bacilli returned showing negative, bronchoscopy was carried out. This yielded tissue consistent with poorly differentiated adenocarcinoma[5]." Dr. Ennis noted Mr. Sistrunk was being transferred to Chateau

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[5] Adenocarcinoma of the lung is a type of bronchogenic carcinoma made up of cuboidal or columnar cells in a discrete mass, usually at the periphery of the lungs. Most such tumors form glandular structures containing mucin, although a minority are solid without mucin. Growth is slow, but there may be early invasion of blood and lymph vessels, giving rise to metastases while the primary lesion is still asymptomatic. Dorland's Illustrated Medical Dictionary 26 (28th ed. 1994).

DeVille Nursing Home. (CX-4, p. 1).

Dr. Ennis completed a discharge summary concerning Mr. Sistrunk on January 25, 1995. Dr. Ennis observed Mr. Sistrunk was hospitalized and placed on large doses of Morphine. "According to his family wishes, no further intervention was carried out and he expired; no autopsy was requested." Dr. Ennis' discharge diagnosis was "metastatic adenocarcinoma of lung (poorly differentiated squamous cell carcinoma)." (CX-20).

Dr. Ennis certified the immediate cause of decedent's death on January 13, 1995, as (a) respiratory failure, and (b) cancer of the lung. (CX-26).

David Witty, M.D.

On October 21, 1994, Dr. David Witty performed a diagnostic bronchoscopy with transbronchial lung biopsies on Mr. Sistrunk. (CX-7). The biopsy tissues revealed "poorly differentiated infiltrating carcinoma consistent with undifferentiated large cell carcinoma." Pathologist James L. Stith opined "most of the ferruginous bodies observed in these biopsy fragments are not of asbestos type, but occasional bodies show the morphologic characteristics of asbestos bodies." (CX-17).

Dewey Lane, M.D.

Dr. Dewey Lane examined Mr. Sistrunk during his hospital admission of October 7, 1994, on a referral from Dr. Ennis. Dr. Lane received a history which revealed Mr. Sistrunk was a "chronic alcoholic and chronic smoker with a history of asbestos exposure, [and had been] hospitalized with a large 8cm abscess in the posterior segment of the right upper lobe which on recent bronchoscopy, was proved to be an abscessed large cell, poorly differentiated carcinoma." Dr. Lane further observed "[Mr. Sistrunk] is eating poorly. He has been on multiple antibiotics with only mild improvement in the inflammatory reaction around the cavitary mass in the right upper lobe." (CX-6, p. 1).

On physical examination, Dr. Lane reported Mr. Sistrunk was a "poorly nourished, lethargic, dull white male who is in his usual posture sitting in a chair. He does not appear to be particular dyspneic in talking to me while he is sitting up but he states that he becomes short of breath when he walks. Apparently, he walks only with insistence and support. He has

a large rhinophyma of the nose. He also has a gross tremor of both wrists and hands, more marked on the right than on the left." Dr. Lane provided an impression "1. Large cavitated, large cell carcinoma of the right upper lobe of the lung, probably originating in the posterior segment. 2. Asbestos in the lungs (ferruginous bodies were identified on the biopsies). 3. COPD from long term smoking. 4. Severe chronic alcoholism with poor nutrition." (CX-6, p. 1).

Dr. Lane performed a mediastinoscopy on Mr. Sistrunk on October 25, 1994. The procedure involved "dissect[ing] out two rather large grayish lymph nodes on the left sides of the trachea and adjacent to the left main stem bronchus. The left recurrent laryngeal nerve was dissected away from the nodes. The nodes were removed in pieces and submitted to pathology." Dr. Lane provided a post-operative diagnosis of "abscessed necrotic poorly differentiated carcinoma of the right upper lobe of the lung." (CX-8).

Richard A. Bucci, M.D.

Dr. Richard Bucci examined Mr. Sistrunk on January 8, 1995, and received a history which revealed Mr. Sistrunk was positive for diabetes, chronic obstructive pulmonary disease, non-Insulin dependent diabetes, poorly differentiated adenocarcinoma of the lung, acute and chronic alcohol abuse, essential systemic hypertension, cigarette abuse, poor nutrition, asbestosis and rhinophyma. Dr. Bucci observed Mr. Sistrunk presented with severe head pain which "maybe secondary to cancer of the lung that he has by history." (CX-21).

Steven Demetropoulos, M.D.

Dr. Steven Demetropoulos completed the death summary for B.J. Sistrunk. Dr. Demetropoulos reported Mr. Sistrunk was a patient of Dr. Ennis with a history of metastatic cancer. Dr. Demetropoulos pronounced Mr. Sistrunk dead at 8:35 p.m. on January 13, 1995. (CX-19).

Richard Kradin, M.D.

Dr. Richard Kradin, board-certified in anatomic pathology and pulmonary medicine and Director of Pulmonary Immunology and Molecular Biology at Harvard Medical School in Boston, Massachusetts, reviewed Mr. Sistrunk's medical records and

histological materials and reported, in a letter to Claimant's counsel dated April 27, 2000:

> In November 1994, Mr. Sistrunk was a 70 year old man who presented to physicians with fever, hyperglycemia and pneumonia. Past medical history was remarkable for asbestosis, chronic bronchitis and diabetes. Chest radiographs revealed a right upper lobe lung abscess, bibasilar reticular abnormalities, and bilateral pleural thickening. A bronchoscopic biopsy showed non-small cell carcinoma and necrotic lung with ferruginous bodies. He died in January of 1995 from complications of his cancer.
>
> Pulmonary function tests on 12/85 showed diminished FEB1 (72% of predicted) with normal FEV1/FVC ratio. The total lung capacity and diffusing capacities were normal. These findings suggest a mixed obstructive/restrictive ventilatory defect.
>
> Mr. Sistrunk had worked as a welder at Ingall's from 1945-48. He returned to Ingall's in 1951 and continued to work there through the 1980's. He reported heavy exposure to asbestos at the shipyard. He was a cigarette smoker of approximately 25-pack years.
>
> I have reviewed 25 slides... The bronchial biopsies show non-small cell undifferentiated carcinoma and necrotic lung. Multiple ferruginous bodies are noted. Some of these show a central lucent core and beading consistent with asbestos bodies. The other ferruginous bodies suggest welding-related siderosis. The number of asbestos bodies is highly suggestive of asbestosis, although pulmonary fibrosis cannot be assessed in the specimen due to the necrosis. Mediastinal lymph nodes show silicotic degeneration.
>
> In summary, it is my opinion that Mr. Sistrunk died from complications of non-small cell undifferentiated carcinoma. The radiographic and histologic findings are consistent with asbestosis. It is my opinion that his lung tumor should be considered an asbestos-related neoplasm and attributed to the combined effects of asbestos and cigarette

smoke. (CX-1, pp. 1-2).

Philip T. Cagle, M.D.

Dr. Philip Cagle, board-certified in anatomic and clinical pathology and Director of the Department of Pathology at Baylor College of Medicine in Houston, Texas, reviewed all of Mr. Sistrunk's medical records, including glass slides and paraffin blocks. In a letter to Mr. Raymond Ulland of F.A. Richard & Associates dated June 20, 2000, he reported:

> HISTORY:
> This 70 year old man had a 20-25 pack-year smoking history, according to Dr. Lorino's report of 12/12/85 and worked as a welder in a shipyard according to Dr. Lorino's report of 12/12/85 and his death certificate. A history and physical by Dr. Calvin Ennis dictated 10/12/94 gives a history of "heavy cigarette smoking, probably 50 pack-year history." He had a history of heavy alcohol intake with rhinophyma and mild gynecomastia, poor nutrition, diabetes and chronic obstructive pulmonary disease. He was suspected of having Parkinsonism. He was diagnosed with carcinoma of the lung and died shortly there after.
>
> MICROSCOPIC:
> Slides labeled 94-6406 show tiny fragments of tissue with a few viable carcinoma cells with mostly necrotic debris. The malignant cells are immunopositive for keratin and NSE on immunostains performed elsewhere. No uninvolved lung parenchyma is present. Several asbestos bodies are present.
>
> Slides labeled 94-6476 show lymph nodes in which there are hyalinized granulomas with focal necrosis. No malignancy is present.
>
> Cytology slides C94-1666 and C94-1665 are negative for malignancy.
>
> COMMENT:
> Over 90% of lung cancers are caused by tobacco smoking. Within reasonable probability, this man's lung cancer can be attributed to his history of tobacco smoking.

> Within reasonable medical probability, in the absence of asbestosis, a lung cancer cannot be attributed to asbestos exposure. There is no lung parenchyma available for the evaluation of the presence or absence of asbestosis.
>
> DIAGNOSIS:
> Lung, bronchoscopic biopsies:
> Poorly differentiated carcinoma with extensive necrosis. (EX-7, pp. 1-2).

Robert N. Jones, M.D.

Dr. Robert Jones, board-certified in internal medicine and pulmonary disease and Professor of Medicine at Tulane University School of Medicine in New Orleans, Louisiana, performed a complete review of the medical records, including chest radiographic studies, in Mr. Sistrunk's case. (EX-5, p. 1). In a letter to Mr. Raymond Ulland of F.A. Richard & Associates dated July 30, 2000, Dr. Jones reported:

> Attribution of lung cancer to asbestos exposures (with reasonable medical certainty) requires a diagnosis of asbestosis. Asbestosis is asbestos-induced lung scarring. The diagnosis can be either clinical-radiological, based primarily on X-rays, or histopathological, based on microscopic examination of lung tissue. In this case, there was no lung tissue (other than tumor cells and necrotic debris) available for a histologic determination of presence or absence of asbestosis. Note that the presence of asbestos bodies, in liquified material from a necrotizing process, provides only indication of past exposure. Exposure does not constitute disease. Any diagnosis of asbestosis in this case must depend on evidence of lung scarring from chest X-rays and CT scans.
>
> The available chest X-rays and CT scans of Mr. Sistrunk show a pleural plaque but no lung scarring, i.e., no asbestosis. In particular, scans made seven and nine years after Dr. Lorino's examination provide no evidence of asbestosis. Had it shown on the films he interpreted, it surely would be seen on the later CT scans. The only reasonable conclusion is that he misinterpreted the 1985 X-rays.

> Pleural plaques have not been accepted as reliable markers of substantially increased lung cancer risk from asbestos exposures. This question has been examined in the literature...
>
> Accordingly, there is no sound basis for imputing Mr. Sistrunk's lung cancer to his asbestos exposure. The only reasonably certain risk factor in his case was his cigarette smoking. (EX-5, pp. 2-3).

The Contentions of the Parties

Claimant contends the death of B.J. Sistrunk was causally related to his asbestos exposure while employed at Employer's shipyard from 1944 to 1984. Claimant further contends Section 33(g) of the Act does not apply and the law firm of Maples and Lomax is not a "representative" under that section of the Act. Claimant argues she is entitled to death benefits, under Section 9 of the Act, including interest and reimbursement of reasonable funeral expenses.

Employer, on the other hand, contends B.J. Sistrunk's death was not related to asbestos exposure while working in Employer's shipyard. Employer alternatively argues that if it is determined Mr. Sistrunk's death was work-related, then Claimant should be barred from receiving benefits based upon unapproved third-party settlements consummated through Claimant's counsel of record.

IV. DISCUSSION

It has been consistently held that the Act must be construed liberally in favor of the claimant. Voris v. Eikel, 346 U.S. 328, 333 (1953); J. V. Vozzolo, Inc. v. Britton, 377 F. 2d 144 (D.C. Cir. 1967). However, the United States Supreme Court has determined that the "true-doubt" rule, which resolves factual doubt in favor of the claimant when the evidence is evenly balanced, violates Section 7(c) of the Administrative Procedure Act, 5 U.S.C. Section 556(d), which specifies that the proponent of a rule or position has the burden of proof. Director, OWCP v. Greenwich Collieries, 512 U.S. 267 (1994), aff'g. 990 F.2d 730 (3rd Cir. 1993).

In arriving at a decision in this matter, it is well-settled that the finder of fact is entitled to determine the credibility

of witnesses, to weigh the evidence and draw his own inferences therefrom, and is not bound to accept the opinion or theory of any particular medical examiners. Avondale Shipyards, Inc. v. Kennel, 914 F.2d 88, 91 (5th Cir. 1988); Atlantic Marine, Inc. and Hartford Accident & Indemnity Co. v. Bruce, 661 F. 2d 898, 900 (5th Cir. 1981); Banks v. Chicago Grain Trimmers Association, Inc., 390 U.S. 459, 467, reh'g denied, 391 U.S. 929 (1968).

A. Causation

Section 20(a) of the Act, 33 U.S.C. Section 920(a), creates a presumption that a claimant's disabling condition is causally related to his employment. In order to invoke the Section 20(a) presumption, a claimant must prove that he suffered a harm and that conditions existed at work or an accident occurred at work that could have caused, aggravated or accelerated the condition. Merrill v. Todd Pacific Shipyards Corp., 25 BRBS 140 (1991); Stevens v. Tacoma Boat Building Co., 23 BRBS 191 (1990).

Claimant's **credible** subjective complaints of symptoms and pain can be sufficient to establish the element of physical harm necessary for a prima facie case and the invocation of the Section 20(a) presumption. See Sylvester v. Bethlehem Steel Corp., 14 BRBS 234, 236 (1981), aff'd sub nom. Sylvester v. Director, OWCP, 681 F.2d 359, 14 BRBS 984 (5th Cir. 1982).

In the present matter, there is uncontroverted evidence that B.J. Sistrunk worked at Employer's shipyard from 1944 to 1948 and again from 1951 to 1984. (CX-33, pp. 3-5). Employer admitted and stipulated there were asbestos products present at its facility during the time B.J. Sistrunk was employed there. (CX-38, p. 2; JX-1).[6] The record is also uncontroverted that B.J. Sistrunk's death on January 13, 1995, was caused by harm to his lungs. (See, e.g., CX-26). Furthermore, Dr. Gaeton Lorino credibly stated B.J. Sistrunk had an asbestos-related lung disease in 1985. (CX-3, p. 3). Consequently, Claimant has invoked the Section 20(a) presumption.

Thus, Claimant has established a prima facie case that B.J. Sistrunk suffered an "injury" under the Act, having established

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[6] Employer asserts even though there were asbestos products present at its facility, B.J. Sistrunk was not exposed to asbestos while employed there. (CX-38, p. 2).

that he suffered a harm or pain by means of his lung tumor, and that his working conditions and activities could have caused the harm or pain for causation sufficient to invoke the Section 20(a) presumption. Cairns v. Matson Terminals, Inc., 21 BRBS 252 (1988).

Once the presumption is invoked, the burden shifts to the employer to rebut the presumption with substantial evidence to the contrary which establishes that the claimant's employment did not cause, contribute to or aggravate his condition. James v. Pate Stevedoring Co., 22 BRBS 271 (1989); Peterson v. General Dynamics Corp., 25 BRBS 71 (1991); see also Conoco, Inc. v. Director, OWCP, 194 F.3d 684, 690, 33 BRBS 187, 191 (CRT) (5th Cir. 1999). "Substantial evidence" means "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." Consolidated Edison Co. v. N.L.R.B., 305 U.S. 197, 229 (1938); E & L Transport Co. v. N.L.R.B., 85 F.3d 1258 (7th Cir. 1996).

An employer must produce facts, not speculation, to overcome the presumption of compensability. Reliance on mere hypothetical probabilities in rejecting a claim is contrary to the presumption created by Section 20(a). See Smith v. Sealand Terminal, 14 BRBS 844 (1982).

In the instant case, Employer has presented substantial evidence to rebut the presumption that B.J. Sistrunk's employment did not cause, contribute to, or aggravate his lung condition.

Employer proffered reports from the Singing River Hospital (SRH) in Pascagoula, Mississippi, wherein the pathology report credibly disclosed the samples from B.J. Sistrunk's biopsy favored a diagnosis of "poorly differentiated infiltrating carcinoma consistent with undifferentiated large cell carcinoma" and not asbestosis. (See CX-17). Along with this pathology report, Employer secured the medical opinions of Drs. Jones and Cagle. Both doctors examined the medical records and chest radiographic studies and performed laboratory studies of the slides and paraffin blocks from B.J. Sistrunk's pleura and lungs to opine that Mr. Sistrunk had carcinoma of the lung and not asbestosis. (See, respectively, EX-5, pp. 2-3; EX-7, pp. 1-2). Because Employer produced facts, and not speculation, that indicate B.J. Sistrunk's death was not attributable to an asbestos-related disease, and therefore work-related, disease, Employer has rebutted the Section 20(a) presumption that B.J. Sistrunk's employment could have caused, contributed to or

aggravated his lung condition. See Smith, supra.

Once the Section 20(a) presumption is rebutted, it falls out of the case and the administrative law judge must then weigh all the evidence and resolve the case based on the record as a whole. Noble Drilling Co. v. Drake, 795 F.2d 478 (5th Cir. 1986); Hislop v. Marine Terminals Corp., 14 BRBS 927 (1982). This rule is an application of the "bursting bubble" theory of evidentiary presumptions, derived from the United States Supreme Court's interpretation of Section 20(d) of the Act. See Del Vecchio v. Bowers, 296 U.S. 280 (1935); see also Brennan v. Bethlehem Steel Corp., 7 BRBS 947 (1978) (applying Del Vecchio to Section 20(a)).

In evaluating the evidence, the fact-finder is entitled to weigh the medical evidence and draw his own inferences from it and is not bound to accept the opinion or theory of any particular medical examiner.[7] Todd Shipyards Corp. v. Donovan, 300 F.2d 741 (5th Cir. 1962). It is solely within the discretion of the administrative law judge to accept or reject all or any part of any testimony according to his judgment. Poole v. National Steel & Shipbuilding Co., 11 BRBS 390 (1979).

In light of the medical and testimonial evidence, I find Claimant has not met her burden in establishing B.J. Sistrunk suffered a harm at work which caused his lung condition.

The medical reports of three pathologists and seven pulmonary specialists have been submitted in this matter. Claimant offered the December 12, 1985 medical report of Dr. Gaeton Lorino who observed B.J. Sistrunk had smoked cigarettes for up to twenty-five years and had sustained prolonged exposure to asbestos. Dr. Lorino opined Mr. Sistrunk had suffered an asbestos-related disease based on pleural thickening present in a chest x-ray and Mr. Sistrunk's prolonged exposure to asbestos. (CX-3, p. 3). However, as noted above, Employer contends B.J. Sistrunk was not exposed to asbestos while working at its shipyard. (See CX-38, p. 2). Moreover, Claimant presented no testimonial or stipulated evidence in the record indicating B.J. Sistrunk sustained asbestos exposure while working at Employer's

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[7] My review includes the cases attached to Claimant's post-hearing brief wherein Dr. Jones, based on the facts presented there, was not credited. I am constrained to the factual matters before me on this record.

shipyard.

Claimant presented the medical reports of Dr. Dewey Lane, who examined B.J. Sistrunk on October 24, 1994. Dr. Lane opined Mr. Sistrunk had "large cavitated, large cell carcinoma of the right upper lobe of the lung." He further opined Mr. Sistrunk had "asbestos in the lungs (ferruginous bodies were identified on the biopsies)." (CX-6, p. 1). After performing a mediastinoscopy, Dr. Lane provided a post-operative diagnosis of "abscessed necrotic poorly differentiated carcinoma of the right upper lobe of the lung," and not asbestosis. (CX-8). Although he states there was "asbestos in the lungs," based apparently upon the ferruginous bodies identified in the biopsy, ferruginous bodies are indicative of iron or iron rust suggestive of siderosis and not asbestosis.

Claimant further presented the medical report of Dr. Richard Bucci, who examined Mr. Sistrunk on January 8, 1995. Dr. Bucci observed Mr. Sistrunk had a history of "asbestosis." However, Dr. Bucci did not present clinical analysis or reasoning for his observation. Dr. Bucci observed Mr. Sistrunk had "cancer of the lung ... by history," but Dr. Bucci failed to document his opinion for the source of Mr. Sistrunk's "cancer of the lung." (CX-21).

Claimant further presented the medical reports of Dr. Calvin Ennis, B.J. Sistrunk's attending physician, and the x-ray and pathology reports of Singing River Hospital (SRH). Dr. Ennis was consistent in reporting his opinion that Mr. Sistrunk had adenocarcinoma and not an asbestos-related disease, namely asbestosis. (See CX-4; CX-5, CX-20). Furthermore, the pathologic laboratory study from SRH determined B.J. Sistrunk's lung condition was a carcinoma and not asbestosis. The pathology report noted there were ferruginous bodies observed in the biopsy fragments, but they were "not of asbestos type." The report further noted "occasional bodies show morphologic characteristics of asbestos bodies," however, the report fails to indicate the significance of this finding and does not provide a diagnosis of asbestosis. (CX-17). Additionally, no chest x-ray from SRH provided a diagnosis of asbestosis in Mr. Sistrunk's case. (See CX-9, CX-10, CX-11, CX-12, CX-13, CX-14, CX-22, CX-23).

Claimants offered the medical opinion of Dr. Richard Kradin, Director of Pulmonary Immunology and Molecular Biology at Harvard Medical School. Dr. Kradin reviewed the medical records

and histological materials in Mr. Sistrunk's case. Dr. Kradin observed Mr. Sistrunk was a cigarette smoker of approximately twenty-five pack-years and noted Mr. Sistrunk had reported sustaining heavy asbestos exposure while working at Employer's shipyard. Dr. Kradin diagnosed "non-small cell undifferentiated carcinoma." He further noted multiple ferruginous bodies, some of which showed a central lucent core and beading consistent with asbestos bodies. Dr. Kradin concluded the number of asbestos bodies present was highly suggestive of asbestosis, however, he remarked pulmonary fibrosis could not be assessed due to necrosis. Dr. Kradin opined Mr. Sistrunk died from complications of non-small cell undifferentiated carcinoma and the radiographic and histologic findings are consistent with asbestos in Mr. Sistrunk's case. He further opined Mr. Sistrunk's lung tumor was an asbestos-related neoplasm which should be attributed to the combined effects of cigarette smoke and asbestos. (CX-1, pp. 1-2).

Dr. Jones reviewed Dr. Kradin's report and observed there was no indication that Dr. Kradin reviewed any radiographic studies nor was there "any description of lung tissue as other than necrotic, which would not furnish histologic evidence of asbestosis." (EX-5, p. 1). Dr. Jones noted that Dr. Kradin did not report any lung scarring, a marker for asbestosis.

Employer proffered the medical opinion of Dr. Philip Cagle, Director of the Department of Pathology at Baylor College of Medicine. Dr. Cagle reviewed all Mr. Sistrunk's medical records and studied the pathology samples. He observed Mr. Sistrunk was a heavy cigarette smoker with probably a fifty pack-year history. On examination of the slides, Dr. Cagle determined malignant cells were immunopositive for keratin and no uninvolved lung parenchyma was present. He did note, however, several asbestos bodies. Dr. Cagle observed there had never been a diagnosis of asbestosis in Mr. Sistrunk's case and opined, within reasonable medical probability that Mr. Sistrunk's lung cancer cannot be attributed to asbestos exposure. He determined the results indicated a poorly differentiated carcinoma of the lung with extensive necrosis. He attributed the carcinoma to Mr. Sistrunk's history of tobacco smoking. (EX-7, pp. 1-2).

Employer also presented the medical reports of Dr. Robert Jones, Professor of Medicine at Tulane University. Dr. Jones performed a complete review of Mr. Sistrunk's medical records and summarized the findings. He noted that lung cancer, to be

attributed to asbestos exposure, requires a diagnosis of asbestosis and no such diagnosis had been made in Mr. Sistrunk's case. The diagnosis can be made via x-rays, which reveal lung scarring. Dr. Jones reported the presence of asbestos bodies, in liquified material from a necrotizing process, provides only an indication of past asbestos exposure, but does not constitute asbestosis. He stated Mr. Sistrunk's chest x-rays and CT scans showed pleural plaques, but not lung scarring and, therefore, was not indicative of asbestosis. He cited recent medical literature for the proposition that pleural plaques are not accepted as reliable markers of lung cancer caused by asbestos exposure. Dr. Jones opined "Accordingly, there is no sound basis for imputing Mr. Sistrunk's lung cancer to his asbestos exposure. The only reasonably certain risk factor in his case was his cigarette smoking." (EX-5, pp. 2-3).

I find the weight of the credible medical and testimonial evidence indicates Mr. Sistrunk's lung cancer was a carcinoma and not an asbestos-related lung disease, namely asbestosis.

The persuasive pathology report from SRH and the well-reasoned opinions of Drs. Jones and Cagle lead to the conclusion that Mr. Sistrunk's lung tumor was not the result of any work-related asbestos exposure, and was likely the result of his history of tobacco smoking.

Drs. Childs, Lorino and Lane opined Mr. Sistrunk had an asbestos-related lung disease, but they presented their opinions before SRH had released its pathology findings, which indicated Mr. Sistrunk had carcinoma and not asbestosis. Indeed, Dr. Lane post-operatively opined Mr. Sistrunk had "abscessed necrotic poorly differentiated carcinoma of the right upper lobe of the lungs." Dr. Ennis, Mr. Sistrunk's own attending physician, consistently opined Mr. Sistrunk's lung tumor as adenocarcinoma and not asbestosis. Dr. Kradin concluded the histological materials were suggestive of asbestosis, but conceded the fibrosis could not be assessed due to necrosis. I find the well-reasoned opinions of Drs. Cagle and Jones more persuasive as they are consistent with the conclusions of SRH. Dr. Cagle determined the malignant cells were immunopositive for keratin. Furthermore, Dr. Jones noted no doctor in Mr. Sistrunk's case had provided a clinical diagnosis of asbestosis and no chest x-ray had found lung scarring, which is the determinative marker of asbestosis. Moreover, Dr. Jones observed pleural plaques are not indicative of lung cancer caused by asbestos exposure. Accordingly, Drs. Cagle and Jones' conclusions regarding Mr.

Sistrunk's lung tumor are more reasoned than Dr. Kradin's conclusion. Therefore, I find and conclude Claimant has not met her burden in establishing B.J. Sistrunk suffered a harm at work which caused his lung condition. See Merrill, supra.

The proponent of a rule or position has the burden of proof in cases resolved under the Administrative Procedure Act. See Greenwich Collieries, supra. Because I conclude Claimant has not established that B.J. Sistrunk suffered from asbestosis, Claimant has not met her burden of proof under the Act. Furthermore, even if the record is considered evenly balanced, Claimant still has not established by a preponderance of the evidence that B.J. Sistrunk suffered from a work-related injury or, alternatively, that there was a connection between B.J. Sistrunk's work and his disease.

In view of the foregoing findings and conclusions, it is unnecessary to resolve the remaining proposed issues relating to Section 33, attorney's fees and interest.

V. ORDER

Based upon the foregoing Findings of Fact, Conclusions of Law, and upon considering the totality of the entire record, it is hereby ordered that Claimant's claim for benefits under the Act is **DENIED**.

ORDERED this 9th day of November, 2000, at Metairie, Louisiana.

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LEE J. ROMERO, JR.
Administrative Law Judge